Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN437AGC	A. BUILDING _____ B. WING _____	10/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST ADULT LIVING	3921 KINGS ROW RENO, NV 89503

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Y 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation initiated on 8/20/08 and completed on 10/20/08, and an annual State Licensure survey conducted in your facility on 9/18/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. Six resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed. Complaint #NV00018957 was substantiated. See Tag Y878. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Y 000		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by:	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 103	Continued From page 1 Based on record review on 9/18/08, the facility failed to ensure 1 of 2 employees met the requirements for tuberculosis (TB) testing (Employee #1). Findings include: Employee #1: The employee has been the administrator/owner of the facility since 1986. The employee's file contained an annual one-step TB test completed on 10/13/07. The was no evidence of a 2006 annual TB test in the employee's file; therefore, the employee would need a second one-step TB test to meet the two-step TB requirement. This is a repeat deficiency from the 9/27/07 annual State Licensure survey. Severity: 2 Scope: 3	Y 103		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 9/18/08, the facility failed to ensure 1 of 2 employees had a criminal history background check (Employee #2). Findings include: Employee #2 was hired on 7/1/07. The employee	Y 105		

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Y 105	Continued From page 2 did not obtain his initial finger prints until 9/20/07, two and a half months after being hired. The facility received notification from the Nevada Repository that the employee's finger prints had been rejected and that new set of finger prints needed to be submitted. A second set of finger print were not obtained by the facility until 9/4/08. The facility had no evidence of a completed background check on Employee #2. Severity: 2 Scope: 3	Y 105		
Y 175 SS=E	449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility. This Regulation is not met as evidenced by: Based on observation on 9/18/08, the facility failed to ensure that 1 of 5 exit doors were not blocked by furniture and the laundry area was free of hazards Findings include: Bedroom #4 was a large room located in the northeast back corner of the house and was approved for three resident beds. The furniture in the room had been rearranged and the three single beds were lined up with their headboards against the north wall of the room. A door with an "EXIT" sign on it was located at the west end of the north wall. The door opened out to a concrete walkway that lead to the front and back yards. The one of the three beds was placed in	Y 175		

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Y 175	Continued From page 3 front of the exit door. There was a sliding glass door on the other side of the room that lead to the back patio. Exiting hazards was a repeat deficiency from the 9/27/07 annual State Licensure survey. There was a build up of lint along the back of the dryer, on the floor and on the wall behind the dryer. Severity: 2 Scope: 2	Y 175		
Y 435 SS=A	449.229(4) Fire Extinguisher; Inspection NAC 449.229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshall to conduct such inspections. This Regulation is not met as evidenced by: Based on observation and interview on 9/18/08, the facility failed to ensure that 1 of 4 facility fire extinguishers were inspected annually. Findings include: The inspection tag on the fire extinguisher near the front door was dated 9/5/07. The administrator reported the facility's fire extinguishers were inspected on 8/11/08 and all the other extinguishers in the facility had inspection tags with this date. The extinguisher by the front door was missed during the inspection. The gage indicator was still in the green "Charged" area.	Y 435		

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Y 435	Continued From page 4 Severity: 1 Scope: 1	Y 435		
Y 878 SS=G	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on interview, observation and record review from 8/20/08 to 10/20/08, the administrator failed to ensure 1 of 6 resident receive prescribed heart and pain medications as prescribed (Resident #4). Findings include: The Bureau received a complaint on 8/14/08 concerning the facility administrator refusing to provide prescribed heart and pain medications to Resident #4 on 8/8/08. The resident was a hospice patient admitted on 5/30/08 with a history of high blood pressure, atrial fibrillation, chronic obstructive pulmonary disease (COPD), chronic pain, anxiety and dementia. The resident received visits from a hospice Certified Nursing Assistant (CNA) three days a week and visits	Y 878		

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Y 878	Continued From page 5 from a Registered Nurse (RN) two days a week. Medications prescribed for the resident on 6/6/08 included: - Lorazepam 0.5 ml, every 30 minutes for anxiety. - Morphine 0.25 ml, every 15 minutes for shortness of breath - Nitro Pump Spray 400 mEq, one spray under the tongue every five minutes for chest pain for a maximum of three doses. On 6/30/08, it was written in hospice notes that Resident #4 was experiencing an increase in restlessness and aggression at night. The Lorazepam instructions were written for the medication to be administered under the tongue every 30 minutes until patient was calm. On 8/13/08, it was written in the hospice notes that the resident had been having chest pain caused by atrial fibrillation and that the Nitro Pump Spray did not always work to alleviate the pain. The new medication administration instructions were for one spray of Nitro under the tongue for chest pain, wait five minutes and if the pain was not resolved to give Morphine, 0.25 ml, under the tongue every 15 minutes until the chest pain was relieved. Interviews with the administrator, hospice personnel, family and record review revealed the following: - The administrator reported Resident #4 was in a nursing home before coming to the facility. The family felt the nursing home was overmedicating their mother because she was "out of it" all the time. Resident's family told the administrator the resident was overly dramatic about her physical and current social condition and requested the administrator not to feed into her "drama." The administrator stated the family told her they wanted to be called before giving the resident	Y 878		

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Y 878	Continued From page 6 Morphine or Nitro so they could be sure she needed it. - On Friday, 8/8/08, the hospice CNA arrived at the facility at 7:45 AM and went to Resident #4's room. The resident was still in bed and was "wincing in pain." The CNA asked the resident if she was "OK" and the resident told her no as she was having stabbing/crushing pain in her chest and down her left arm. The CNA stated she had worked with the resident for two to three months and the resident had chronic pain complaints, but the pain the resident was describing was different and she looked different. - The CNA went to find the administrator, Employee #1, to tell her about the resident's chest and arm pain. The administrator told the CNA that the resident always complained of pain and went to the resident's room. The administrator reported the resident told her she was wet with urine and wanted to be cleaned up and changed. The administrator said she believed the resident's chest pain could not be as bad as the resident indicated if the resident wanted to be cleaned up. The administrator stated she did not feel the resident needed any medication for her chest pain and began to change her incontinence brief. - The CNA called her hospice nurse administrator and explained the situation, her concerns about the resident's pain and the administrator's refusal to use medication. The nurse administrator reported to the CNA that a hospice RN had been called, was on the way to the facility and instructed the CNA to tell the group home owner to give the resident Morphine. - When the CNA went back into the facility, she found the administrator was getting the resident out of bed to take her to the bathroom to shower her. The CNA told the administrator her supervisor stated the resident needed to be	Y 878		

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Y 878	Continued From page 7 medicated for the chest pain and suggested they leave the resident in bed until the RN arrived. - The administrator reported she helped the resident out of bed and took to her to the bathroom to shower her and wash her face. The administrator then helped the resident get dressed and took the resident out to her chair in the living room. She stated the resident seemed fine. -The CNA stated she could see the resident was still in pain while the administrator dressed the resident and walked her to a recliner in the living room. The CNA reported the administrator left the resident in the recliner and went to the kitchen to make breakfast. At 8:30 AM, the administrator had still not given the resident any medication. - The CNA reported the hospice RN arrived at the facility at 9:00 AM. The RN reported he found the resident sitting in a recliner in the living room with a tray of food placed near the chair. The RN stated the resident was grasping her chest complaining of chest pain and taking deep breaths. He noted the resident was pale, her respirations were at 34 per minute and her heart rate was 105 beats per minute (BPM). - The administrator reported that when the RN arrived he asked her why she did not give the resident medication for the chest pain. The administrator stated she told the RN that the resident was able to function - as in wash, dress and get to the living room - so she thought the resident did not need any medications. - The RN stated he asked the administrator for the resident's pain medication which she obtained for him and he gave a dose of morphine to the resident. The CNA reported the RN asked the administrator if the resident had any heart medications and the administrator indicated the resident did not. - The RN reported he transferred the resident	Y 878		

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Y 878	Continued From page 8 from the recliner to a wheelchair, took her to her room and transferred her to the bed. He elevated the head of the bed to a 45 degree angle and noted the resident's breathing and pain were somewhat relieved with this change in position. - The RN reviewed the resident's medication sheet and found that Niro Spray was available. The RN sent the CNA to obtain the Nitro from the administrator and then the nurse medicated the resident with one spray of Nitro. - The CNA stated that at 9:30 AM, the RN told the CNA to obtain another dose of morphine for the resident. The administrator refused to give any more morphine to the CNA stating she had called the resident's daughter and the daughter was coming to the facility. The CNA related that the daughter arrived a few moments later. - The RN talked to the daughter and after seeing the resident, she gave permission for a second dose of morphine. The RN documented that after the morphine, the resident's breathing rate declined to 20 respirations per minute and her breathing became relaxed and unlabored. The resident reported to the RN her pain was eased and when he measured the resident's pulse rate, it had declined to 80 BPM. - After the resident was stabilized, the RN reported he held a conference with resident's daughter and the administrator. The RN reported the daughter expressed her concern that the resident would be overmedicated if given morphine as it was prescribed and that she would become more confused. She was also concerned that her mother would be "out of it" when she passed on. The RN reported he discussed with the daughter and the administrator the need to give the medications based on the resident's symptoms so the resident was comfortable to improve her quality of life.	Y 878		

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Y 878	Continued From page 9 The administrator reported during interviews that she was complying with the wishes of the family to not medicate Resident #4 unless she was sure the resident really needed the medication and was not just being "dramatic." The family also reported in interviews they had instructed the administrator not to medicate the resident without their permission. The administrator, the family and the hospice nurse administrator all reported they had conferences concerning the resident not receiving medications as they were prescribed and the events of 8/8/08. The hospice nurse administrator reported the resident was prescribed a Duragesic Patch on 8/27/08 for her chronic pain. The hospice nurse administrator stated the pain patch would help the resident remain more comfortable and did not require intervention by the facility administrator. Resident #4 was in a recliner in the living room on 8/20/08. During an interview she complained of being in constant pain and stated her back pain bothered her than her chest pain. She stated she still had shortness of breath even while using portable oxygen. The resident was interviewed in her living room recliner again on 9/18/08 and she stated she was much more comfortable and was notably cheerier and more talkative. Severity: 3 Scope: 1	Y 878		
Y 936 SS=D	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all	Y 936		

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Y 936	Continued From page 10 records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 9/18/08, the facility failed to ensure 1 of 6 residents met the requirements of tuberculosis (TB) testing (Resident #5). Findings include: Resident #5 was admitted on 5/22/00. A two-step TB test was completed on the resident on 9/14/06 and the file contained a one-step TB test dated 5/15/08. This resident was cited on the 9/27/07 annual State Licensure survey for not having an annual TB test by 9/14/07. The administrator reported a two-step TB test was completed on the resident and submitted this information with the Plan of Correction for the survey. A copy of the 2007 TB test was not in the resident's file and the resident will need an additional one-step TB test to meet the TB testing requirements. Repeat deficiency from the 9/14/07 annual State Licensure survey. Severity: 2 Scope: 2	Y 936		
YA908 SS=B	449.2746(2)(a-f)PRN Medication Record NAC 449.2746 2. A caregiver who administers medication to a resident as needed	YA908		

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YA908	Continued From page 11 shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Based on record review and interview on 9/18/08, the facility failed to ensure all as needed (PRN) medications were documented for 1 of 6 residents (Resident #5). Findings include: The facility was cited on the 9/27/07 annual State Licensure survey for not documenting PRN medication administration to residents. The administrator indicated on the Plan of Correction (POC) for the survey that the facility would begin using a separate PRN medication sheet to document administration of PRNs to residents. The administrator provided a copy of the sheet for review and PRN medication sheets were found in the resident's records. Resident #5 was prescribed Ibuprofen 200 milligrams (mg), three times a day PRN for pain on 8/20/08 and the medication was filled on	YA908		

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YA908	Continued From page 12 8/22/08. The administrator reported she started giving the resident the medication when the resident requested as of 8/22/08. The medication was not listed on the PRN medication sheet with the resident's other PRN medications. The administrator stated she was not documenting the administration of the medication because there was no room on the PRN sheet to add the medication. The administrator admitted that she could have added another copy of the PRN sheet to the resident's file. Repeat deficiency from the 9/27/07 annual Stated Licensure survey. Severity: 1 Scope: 2	YA908		